CDC *Vital Signs* HIV/AIDS Webinar

Lessons Learned and Success Stories

Transcript

December 6, 2010
2:00pm – 3:30pm EST

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode until the question and answer portion of today's call.

If you would like to ask a question at that time please press star then 1 on your touch-tone phone. This conference is being recorded. If you have any objection you may disconnect at this time.

Now I'll turn the call over to your host, Dr. Judy Monroe. Thank you doctor, you may begin.

Dr. Judy Monroe: Thank you very much. Well welcome everyone and I thank all of you for joining us today for the first CDC Vital Signs Webinar hosted by the Office for State, Tribal, Local and Territorial Support.

I'm Judy Monroe, director of OSTLTS and it is with great pleasure that I introduce to you CDC's director Dr. Tom Frieden to kick off our inaugural event. So Dr. Frieden?

Dr. Tom Frieden: Thank you very much, thank you all for joining. Good afternoon and welcome to the first Vital Signs Webinar. Vital Signs was launched five months ago to share our data and progress addressing the leading health indicators in the US.

It's more than data, it's a call to action. I'm delighted that you're participating in this Webinar and encourage you to actively participate. The information released last week on HIV testing is good news.

Progress has been made, more people are being tested and that shows that more progress can be made - which is good, because more progress is needed.

HIV as you all know is still a very serious problem in this country, testing and linkage to care are key to decreasing the epidemic over the past three years, 11 million Americans were tested for the first time and we saw essentially a 5% increase, 5% absolute 15% relative increase in testing.

And related to that a 5% absolute 15% relative decrease in late diagnosis. So real progress, but not enough because 200,000 Americans or more still have HIV and don't know that they have it.

And unless you know you cannot as effectively reduce risk, protect yourself and protect others. Your work is critical to continuing this positive trend, reducing the incidence of HIV and I hope again that you'll use this time to learn from each other, engage in open dialogue.

Talk about the things that have worked and maybe been the things that haven't worked so well, both of those things are useful for all of us to learn about, what paths to go down and what paths to maybe consider reengineering a bit before we try to go down them, sharing common barriers and strategies to move forward and build success.

So with that thanks to all of you, I'll turn it back over to Dr. Monroe.

Dr. Judy Monroe: Thank you Dr. Frieden, appreciate you being on the call today. So for all of you as Dr. Frieden just mentioned this is really about success and about our lessons learned.

And knowing what doesn't work as well. Today we have the opportunity to continue to support each other and to build the momentum around the action for Vital Signs.

And you heard Dr. Frieden say this, Vital Signs is really a call to action to the field and to all of us to work together. Vital Signs is really a great tool for sharing data and we want you to share that data with not just the public health community but the public as well.

We continue to see where public health needs to be much more visible. Each month we get the release, we hear the press conference with Dr. Frieden when the release comes out and then we hear from the CDC expert on the topic.

But then the question is what happens? We've put data out, now what do we do? I've heard from many of you as I've been in this position now at CDC, I know there's a lot going on around the country.

And so today through this Webinar we're taking the opportunity to share what we're doing, to hear the great stories from the field and work to increase the momentum around the Vital Signs data.

We can take this information and then together we can tackle these issues and then at the end of the day it's all about having meaningful impact on the health nation wide.

Vital Signs provides information that's really perfect for outreach to the media and I would really encourage all of you to find ways to reach out to your local media using Vital Signs, and maybe some things that you hear on the call today on this Webinar might spark some ideas for what you might do in the next weeks to come.

So this is what these releases really are all about, it's all about us making it happen. But then making it known that we made it happen and I can't overemphasize that. I mean too often public health is very successful at what we do but no one knows that we did it.

And so we need to make the visible - the invisible visible. And this really is a prime priority for us.

For me personally as a family physician, I practiced in Appalachia, I directed a residency program. I was a state health official, now I'm in a leadership role here at CDC.

And there's no doubt in all those experiences that the way we really reach our goals is through collaboration, the problems that we're trying to address take all of us.

And it's through that open communication and again that's what we're really trying to achieve on the Webinars is to take this data and really put it into action but to support one another and to share those ideas and help one another go forward.

So with that we have a great line up today, I'm really pleased with this first Webinar and the speakers you're going to hear from over the next hour.

You're going to hear how Vital Signs has been used to garner support and form partnerships and challenges and keys to success for public health programs.

We've also scheduled some time for question and answer at the end of the call. We want to hear from you, we want to have this conversation be ongoing. You can send your questions to us at any time during the Webinar.

So before we get started I have a few housekeeping details for those joining us by phone only, you can access today's slides from the OSTLTS home page, that's www.cdc.gov/ostlts.

Check on the Vital Signs Webinar in the flash module at the top of the OSTLTS home page and it's going to take you to the site where the PowerPoint presentations are located.

Also we certainly know that your time is valuable and your input is valuable so we'd like for you - we really ask that you participate in a very short survey at the end of the Webinar so after 3:00 pm it too will be found on the OSTLTS Vital Signs page.

And so now at this point it's my distinct pleasure to introduce the president of two of our national organizations, associations that share with CDC the common mission of improving the health of the public through health promotion and disease prevention.

So I'm going to turn things over now to John Auerbach, president of ASTHO and (Carol Moehrle), President of NACHO. So John?

John Auerbach: Well thanks very much Dr. Monroe. On behalf of ASTHO as well as the State Health Commissioner and in Massachusetts, I'm really happy to participate in this call for a number of reasons. First I want to applaud CDC for its development of Vital Signs.

Our ability to function well as advisors to our governors, our legislators and our community partners at all levels is incredibly enhanced when we have the state of the art knowledge and the tools that Vital Signs is now providing us.

And secondly we are grateful that CDC has involved ASTHO as well as NACCHO, our partner in local health in the planning and implementation of these efforts and our inclusion in this call is just a symbol of that and a credit to the type of leadership that Dr. Frieden and Dr. Monroe represent.

I'm also really pleased with the topic of this call it's focused on HIV and AIDS. I myself am an ex-state AIDS director and a proud former member of NAFSTAD and I believe that we need to focus our attention on HIV and ensure that we're continually adapting and strengthening our work and not letting it weaken or become out of date.

I know in our state we've been actively working on the counseling and testing prevention service mix that addresses the evolving needs and conditions and we'll definitely benefit from hearing the presentations today and participating in the discussion.

And then just finally I want to relay that as ASTHO president this year, I've identified a prioritized area for attention among health officers, namely the promotion of health equity and the elimination of racial, ethnic and other disparities.

And this dovetails nicely with CDC and many other organization's growing attention to social determinants of health such as poverty and racism and those certainly are clearly illustrated as we address the HIV epidemic where racial, ethnic and class differences are very much still involved in addressing the issues of HIV as well as homophobia.

So here too CDC Vital Signs I just want to say thank you for your great leadership and ASTHO will pledge it's ongoing support to this good work and collaborate to ensure that the information and materials that you're producing and the forums like today are widely utilized.

Dr. Judy Monroe: Thanks John, (Carol)?

Carol Moehrle: Good morning. Thank you Judy for hosting us again today and like John said NACCHO also applauds CDC for developing these Vital Signs on a monthly basis as tools for us at the state and local level in this governmental public health arena that we are all sharing, that we can use these to be talking from a consistent message and a consistent format.

So this is very helpful. On a NACCHO perspective at that national level, NACCHO has - is working on many initiatives focused on technical assistance to local health departments, helping local build on HIV prevention capacities. And working with some peer to peer technical assistance also, as we all know the importance of HIV testing, monitoring and the continued education that we need to be giving in our local communities so that people awareness continues to be heightened around this issue.

NACCHO also helps collect and disseminate best practices that locals are working on with HIV prevention programs and those are helping all of us so that we're not reinventing the wheel but using best practices to further our HIV efforts at the state and local levels.

On a personal note I'm a local health officer in North Central Idaho. When Dr. Frieden and Dr. Monroe introduced the Vital Signs I was thrilled.

It's now become a regular part of what I use in my health district to educate not only my elected officials, my board members but also my staff as we give the same consistent message and we're using these monthly Vital Signs in order to promote science based database messages coming out of CDC.

These - at the local level as you all know if you're locals out there, we have a lot of opportunities to connect with our local media. They are often times just searching for stories and we can help tell the story on the local level as it relates to what CDC has already done for us with these wonderful documents around the Vital Signs.

Many of us at the local level have monthly health messages that we do with the media, some of us do weekly radio shows. We all - if you report to a board at all the policy makers meet on a regular basis.

I am using each one of those avenues here in Idaho in order to share the Vital Signs stories. And it has just been overwhelmingly received with positive remarks and I'm feeling so good that our elected officials, the staff, the public are hearing the stories that local public health agencies are doing to support the activity that CDC is now documenting in these Vital Signs reports.

So if I can just - any locals on there use these, they are a valuable resource for us and opportunity for us to be speaking the same voice, the same message as local states and CDC are presenting these Vital Signs topics on a monthly basis to our public.

So from a local perspective too, I want to thank Dr. Frieden and Dr. Monroe for their leadership in these Vital Signs and especially around the one today that we're kicking off on HIV. And look forward to the other months ahead as NACCHO, ASTHO, and CDC work cooperatively to spread this message, science and data based on these top Vital Signs that are identified.

Thank you Judy again for allowing us to participate today.

Dr. Judy Monroe: Well thank you. You guys can tell listening to John and Carol I think we have the dynamic duo this year with the presence of ASTHO and NACCHO from

John's experience that he talked about as president of challenge and Carol I love what you're saying about the peer to peer to work, best practices.

Using Vital Signs in your jurisdictions back home for the data, but then telling the story and that's at that local level that you really have the stories that will speak to the public and the policy makers.

So I think that's fantastic. A reminder to all of you we already have received a few questions, I encourage anyone that has a question to go ahead and submit them now as you go through if you think of questions that you're going to have.

And we'll be compiling those for the Q&A at the end. So it's a real opportunity that our first Webinar coincided with the monthly Vital Signs on HIV and AIDS and world AIDS Day. There's great work being done here at CDC and throughout the public health system to help prevent HIV and to get people tested.

As you've already heard on the call and connected with treatment. And I know there's broader support since the release of the White House national HIV AIDS strategy this summer.

We are very pleased to have us joining the call today two major players in these efforts, Dr. Jono Mermin, the Director of CDC's Division of HIV AIDS Prevention and Julie Scofield, Executive Director of the National Alliance of State and Territorial AIDS directors.

I know they have much to share about this month's Vital Signs topic. So let's go ahead and transition, I want to go ahead and turn over to Dr. Mermin.

Dr. Jonathan Mermin: Well good afternoon and thank you Dr. Monroe. I'm going to begin by providing some background on the HIV epidemic in the US, some recent developments in HIV prevention and an overview of the Vital Signs article including the public health implications of the data and how states and other partners can take action.

So more than 1 million people in the US are living with HIV. And more than 200,000 of them, or one in five people do not know they are infected.

More than 50,000 new infections occur each year. This is not only a human tragedy, but it is costly financially. Currently the US spends about $21 billion annually to treat people with HIV.

Yet this crisis also presents us with opportunity and it's an exciting time for HIV prevention. As Dr. Monroe mentioned this summer the White House released the nation's first national HIV AIDS strategy which charged us with reducing new infections, improving linkage to and quality of care and targeting those at highest risk.

We have a toolbox of effective interventions such as condoms, behavior change and HIV testing that have been effectively used to prevent HIV though perhaps not the scale necessary to make dramatic inroads into the epidemic recently.

At the same time we've seen substantial advances in biomedical approaches to prevention such as antiretroviral therapy, vaginal microbicides and pre-exposure prophylaxis.

Expanding use of old tools and using new interventions to their fullest provide us with substantial opportunity.

This comes at a good time for HIV prevention. We have made significant progress in the past 30 years but we have more work to do. This graph shows the number of new HIV infections, the orange line on the bottom and the number of people living with HIV AIDS, the blue line on the top.

As you can see incidence has remained relatively stable while prevalence has seen a steady climb.

The fact that we have been able to hold incidence steady while prevalence is rising due to increased access to life prolonging treatment is a testament to the work we've all been doing to prevent new infections.

But our jobs will only get more difficult as prevalence continues to increase because there will be more opportunities for new infections to occur.

Although HIV is an issue for the entire nation it is not evenly distributed across the country or among different populations.

This map shows the distribution of AIDS diagnoses per 100,000 adults by state, the darker the state, the higher the rates of AIDS diagnoses in 2008.

We can see that the states with larger populations as well as those in the south and northeast generally have higher rates of AIDS.

This is important information as we talk about testing because it shows us where increased efforts may be more likely to diagnose more people with HIV.

Now I'd like to discuss the methods used for the Vital Signs article. The data came from two main sources, the first is the National Health Interview Survey.

This continuous project conducts in person household surveys. In 2009 88,000 individuals were surveyed from 34,000 households in the country.

We also used core HIV AIDS surveillance data which CDC collects in partnership with states. The AIDS rate data for the report came from all states. HIV data are from the states with long term confidential name based HIV reporting systems.

We found that 83 million people aged 18 to 64 years old had been tested for HIV at least once. And that more than 11 million were newly tested between 2006 and 2009.

However, 55% have never been tested and 28% of people at high risk for HIV have never been tested. Even among those who have been tested many people are not getting tested often enough.

For example, youth age 18 to 24 have lower testing rates than other age groups. Men who have sex with men make up 55% of HIV infections in the US but only two in five were tested in the past year.

And other research tells us that about three quarters of the men who have sex with men who are unaware of their HIV infection reported visiting a healthcare provider in the past year.

African Americans also make up more than half of HIV infections, yet while their testing rates were higher still only three in five have ever been tested.

Finally we found that nearly one third of HIV infections are diagnosed late. We define a late diagnosis as an HIV diagnosis that is followed by an AIDS diagnoses within one year or if both are diagnosed simultaneously.

The average time between HIV infection and AIDS is ten years. This is a concern because it means people have likely been infected for years without knowing it so they've missed opportunities for more effective treatment and opportunities to protect their partners.

The data here presents a compelling case for HIV testing, especially when we can see them graphically. This figure compares the percentage of people who have ever been tested for HIV to the percentage of late diagnosis.

The darker blue line on top shows an increase in the number of people ever tested, especially recently. The light blue line on the bottom shows the decrease in late diagnosis.

HIV is a preventable infection and by preventing HIV or its progression, AIDS is also preventable. Yet 37,000 people in the US were diagnosed with AIDS in 2008. The people who are infected with HIV need to know their status.

If they don't they can't get treatment and treatment is most effective when people get it early. They also can't protect their partners from HIV either by taking treatment and reducing the amount of virus in their body and associated chance of transmission or by protecting their partners.

Studies show that the majority of people who know of their HIV infection reduce their risk behavior. HIV prevention is also cost effective.

The healthcare system spends $367,000 in lifetime medical costs for one case of HIV. In 2006 CDC recommended routine opt out HIV testing in clinical settings.

We know our partners have been working hard to adopt these recommendations and we've collaborated on a variety of things to ensure the testing rates increase.

Our expanded testing initiative collaborates with 30 jurisdictions with high HIV prevalence to focus on groups at heightened risk for HI, African Americans, Latinos, injection drug users and gays, bisexuals and other men who have sex with men.

We've seen progress in the first three years of this initiative and the new phase that began in April of this year is expected to total about $142 million over the next three years.

The increase test in CDC also collaborates with professional organizations such as the Society for General Internal Medicine, the National Medical Association, the American College of Obstetricians and Gynecologists, the National Association of Community Health Centers and the American Academy of HIV Medicine as well as health departments, a multitude of community based organizations and other federal agencies such as HERSA.

Finally CDC launched the act against AIDS communications campaign last year to reengage Americans in the fight against HIV. It includes social marketing and social media messages for the most affected communities as well as materials to assist providers in implementing routine testing recommendations.

The Vital Signs is really a call for action. Our testing efforts are showing results but we have a long way to go. Partnerships are the key to future success and I encourage you to collaborate with the federal government, state and local health departments, community based organizations and other

partners to work together to ensure your state and local policies are supportive of HIV testing.

To expand HIV testing and increase both linkage to care and retention of people who are receiving care. To educate about the benefits of testing and early treatment for those who are HIV positive and to integrate HIV prevention and care services as well as supporting community prevention efforts.

So if you'd like more information please visit www.cdc.gov/vitalsigns or www.cdc.gov/hiv for the CDC Website pages on HIV. Thank you.

Dr. Judy Monroe: Thank you Dr. Mermin. And now we'll move to Julie Scofield.

Julie Scofield: Thank you Dr. Monroe and good afternoon everyone. As we get rolling on this afternoon just let me introduce NASTAD, we are the ASTHO affiliate that represents the state health department HIV AIDS and viral hepatitis programs.

And like ASTHO we have an office here in DC providing technical assistance and working on the national level to provide policy and program leadership and to educate and advocate for our programs.

Really want to thank Dr. Monroe for inviting us to participate in this inaugural Vital Signs Webinar. The office of State, Tribal, Local and Territorial support is a new acronym for us.

But we are so happy to have such an incredible seasoned leader in that role and I very much appreciate the opportunity to be with you all this afternoon. In terms of responding to the HIV AIDS epidemic here in the United States I think we are really at a unique time in our history.

I sometimes describe it as the best of times and the worst of times all at once, but we have a number of opportunities and challenges and I think in the near term it's going to be very interesting to see whether or not we can bring all the right resources and expertise to turn the corner on the epidemic here at home.

As has been mentioned President Obama released a national HIV AIDS strategy in July and what's really notable about that national strategy, when you get into the details of its implementation it relies heavily on state and local health departments to respond by developing a comprehensive state HIV AIDS plan.

And so we know implementation of a national strategy can't happen in Washington, DC and it really relies on mobilization across the country. We also are very pleased that Dr. Frieden has named HIV AIDS one of CDC's winnable battles.

And while we know there are many, many, many great programs at CDC we would agree that HIV AIDS is an area where if we really pool our resources and intentions and science base together we can make some progress.

And then finally have to mention that heath reform really holds great promise for our ability to respond to this epidemic and care for people with HIV although some of that promise is down the road.

We are very, very happy that HIV AIDS receives $30 million from the prevention and public health fund this year and I hope everyone on the line today will be working with us over the next year to make sure we preserve that prevention and public health fund which is going to be so vital to enhancing our capacity across public health to do the work across many different areas.

Then we have some amazing challenges in front of us, I - earlier today gave a presentation about what we've been able to quantify in terms of the impact of the state budget crisis on HIV AIDS, STD and viral hepatitis programs.

And we know from our assessment of our programs that we've lost about $230 million over the last two years in state general revenue support for HIV, STD and viral hepatitis programs.

That is a huge amount of lost resource and we are very concerned about that. And at the same time I think we all know that the public health workforce is very much in crisis as well.

And I think we all need to collectively work to do - to see what we can do to do a better job of supporting that workforce that we're going to need to be able to make progress.

We have an AIDS drug assistance program crisis, 4,369 people on waiting lists in nine states. And like John Auerbach mentioned we have our own version of a presidential challenge.

And our current chair Ann Robbins from Texas has lead the way for a statement of urgency on HIV and STDs among gay men and other MSM, there continue to be unacceptably high numbers of new infections.

And that is a trend that we're really hoping that all the health departments across the country will take a look at in a new and renewed sense of urgency to try to do a better job responding.

But what we really want to focus on this afternoon is a notable success. And this success, Dr. Mermin mentioned is CDC's expanded testing initiative. We

really believe there's some - a lot of great news and some very strong momentum here.

This initiative was launched in September of 2007 with a goal of conducting 1.5 million HIV tests and identifying 20,000 new HIV infections a year for three years.

So there was the first three year project period, we have now in September started a second three year product period, initially only 25 jurisdictions were funded for expanded testing, now 30 jurisdictions are funded.

Under the current program 70% of those tests are required to be in clinical settings, the rest can be in other venues and can be targeted testing. An initial focus on African Americans has been expanded to be inclusive of other high risk populations including Latinos, gay men and other MSMs and IDUs.

And I think we had some very good news as we were really looking at the success of this initiative in the first three years that with those enhanced testing resources and 25 jurisdictions 2.66 million HIV tests were conducted, 27,766 new confirmed HIV positive individuals were found.

That we were very successful in targeted intended populations of African Americans and I think best of all of those tested and found positive 75% were linked to care.

So we think that has been a great success and we really hope in the second three year project period we will continue to make significant progress in expanding the opportunity for people to know their status and to be linked to care.

Next I wanted to talk a little bit about the results of a survey we conducted very early this year to assess progress across health departments in implementing HIV testing and healthcare settings and to be responsive to CDC's 2006 guidelines for HIV counseling and testing in healthcare settings.

So first the barriers that have been identified. It should surprise no one that lack of adequate funding provider and health facility resistance are indeed barriers to implementing HIV testing in healthcare settings.

We know that from talking with our members and from this survey that hospital emergency departments, correctional facilities and community health centers are the most challenging environments in which to implement routine HIV testing.

Provider education and awareness efforts have to be a part of our strategies for moving forward. And I think what's really important and an area where I hope that we will see some significant improvement, particularly with healthcare reform is reimbursement for HIV testing.

That is a key concern for health departments in their efforts to expand routine testing in clinical care settings.

But we also found some very good news in our survey of health departments in terms of their efforts to expand the opportunities for testing. Since 2007 the state legal and policy environment offers increased flexibility for HIV testing.

In 2010 fewer health departments report that separate consent for HIV testing is required by statute of regulation and fewer reported that pre-test counseling is required prior to HIV testing.

Substantially more health departments reported that routine offering of HIV testing in healthcare settings with right of refusal is allowed by statute regulation or policy and that the legal environment for HIV testing at the state level has been changed and is now largely responsive to CDC's recommendations around routine testing.

Before we head out to hear how this is being experienced in a couple of jurisdictions we also found in our survey that state health departments have increased investments in HIV testing in health care settings.

Nearly all health departments reported supporting HIV testing efforts in healthcare settings in 2010 while only 35 reported doing so in 2007. Three quarters of health departments reported supporting the routine offering of HIV testing to all patients age 13 to 64 years without regard to clinical signs or symptoms of behavioral risk.

So we know we faced an incredibly challenging environment, we're going to have to all work together to secure ongoing support for activities but I do believe that we've seen signs of amazing progress in expanding the reach of our programs, particularly around making testing available across the country.

So on that note I'm going to turn it back over and out to the field. Here's my contact information if anybody has any other questions.

Dr. Judy Monroe: Thank you Julie very, very much and I want to thank Dr. Mermin again as well for both of you sharing from the national perspective the work being done and yet to come around HIV and AIDS prevention.

So now as Julie said we want to move to the field. And I have the pleasure to introduce our next two speakers to share experience on their efforts in HIV prevention at the state and local levels.

First speaker will be Heather Hauck, Director of Infectious Disease and Environmental Health Administration at the Maryland Department of Health and Mental Hygiene and following her will be Dr. Ann Robbins, manager, HIV STD Prevention and Care branch at the Texas Department of State Health Services. So Heather?

Heather Hauck: Great, thank you Dr. Monroe and thank you to CDC for the opportunity to talk about HIV testing in Maryland today. I also want to acknowledge and thank our Maryland DHMH secretary John Colmers and Deputy Secretary for public health services Fran Phillips for their ongoing support of our HIV prevention and care portfolio.

Including their willingness to test publicly for HIV and demonstrate the importance of having leadership around HIV testing in our state. Our first slide we always start with our mission of our administration, very similar to other people's missions across the jurisdictions.

I think the second part we like to highlight is the fact that we work in partnership with many entities to provide the public health leadership to prevent, control and monitor and treat infectious diseases and environmental health hazards.

I'm going to spend my time this afternoon talking in four areas which are mainly the strategies that we've used over the past few years to increase HIV testing in Maryland, mainly policy and legislative changes.

I'm going to describe briefly our comprehensive HIV testing program, our partnerships collaboration and integration efforts and of course our need to continue provider education capacity building and technical assistance.

So in terms of policy and legislation as has already been alluded to, CDC's recommendations for HIV testing in clinical settings came out in late 2006. We spent here in Maryland 2007 convening and walking through an intensive stakeholder process that allowed us to develop a legislative proposal and garner sponsorship for legislation in our general assembly in 2008.

Legislation was passed in our general assembly in 2008 and the next two slides just describe some of the changes that we made in terms of our HIV testing law primarily that we streamlined the pre-test counseling information to make it easier on providers to be able to deliver appropriate pre-test counseling.

And its healthcare settings we did eliminate the separate written consent. Inform consent must be documented in the medical record but no longer is necessary to be documented on a separate written consent form.

And non-healthcare settings because they typically do not have a medical record we do require that they continue to use a uniform inform consent form developed and provided by the department.

We also took the opportunity to update the testing law around the offering and documentation of testing for pregnant women in the state. Again our goal is to reach zero perinatal transmissions and felt that this was an opportunity for us to update our policy around that.

So we view our HIV testing program in the state of Maryland as being the keystone for testing and not specific to testing in healthcare settings, non-healthcare settings, targeted routine opt-in, opt-out or even between public or privately funded testing.

But really being the foundation and the keystone in providing technical assistance. It might be funding, it might be other sorts of policy implementation efforts in these various areas in order to promote the offering of HIV test to all Marylanders on at least an annual basis.

We also view testing as not just the act of diagnosis but also the linkage to care and partner services components of testing. And so our testing program works comprehensively and intensively across these various areas to ensure that it's a seamless system.

We support a variety of testing strategies in diverse settings and we've listed them here. We have anonymous and confidential testing, we offer conventional testing as well as rapid testing, targeted and routine and in clinical and non-clinical settings.

We have approximately 70 agencies that are publicly funded or supported and I'll describe the difference in a second that then translate into over 350 active sites across the state, that includes local health departments, community based organizations, faith based organizations, community health centers, corrections, drug treatment centers, perinatal clinic, and emergency departments.

And we provide support in two ways. We either directly fund an entity to support the infrastructure, the staffing, the test kits etcetera or in most cases we actually provide what we call indirect support and that is intensive technical assistance to be able to provide HIV testing and counseling.

The free use of our state lab, rapid test kits, but not necessarily financial support for any other infrastructure efforts so we really do rely on the partnership and collaboration of those entities that will work with us with our indirectly funded sites or independently supported sites.

The next couple of slides are a couple of numbers to give you a sense of impact, especially in terms of the expanded testing initiative. I think you'll see that those expanded testing initiative funding resources have really allowed us to launch into a greater phase of our HIV testing initiatives.

In 2007 with our regular foundational CTR program we tested a little over 50,000. By the end of 2009 we were able to test about 100,000 individuals and that expanded testing initiative resource allowed us to move into areas that we had not previously been able to work as intensively as we wanted to including emergency departments in both Baltimore City and Prince George's County which are the areas with the most disease burden in our state.

As well as some community health centers and some other settings like substance abuse settings. We have through the years and certainly with additional resources through the ETI program been able to fund a significantly increased number of newly identified HIV positive clients.

We also think that it's important that this program has been able to allow us to connect with individuals a little over 600 individuals who are previously diagnosed with HIV but had not yet engaged in the care system.

So equally as important to us as the individuals that are newly identified, it also allows us to work with people who were previously known to be positive and get them into our healthcare system here in Maryland.

And then the last number and last stat slide is just around our positivity in relation to our volume which it's been fairly consistent as you can see over the past few years.

So in terms of partnership collaboration and integration which is really where the rubber hits the road for us, as you can see we work with a diverse array of public, private, clinical and non-clinical agencies.

We really have been working over the past two years at system level partnerships, working in systems like our sexually transmitted infections clinics across the state.

Working with our behavioral health counterparts, our mental health facilities and group home settings. Working with our substance abuse system including BSAS which is our substance abuse system here in Maryland, here in Baltimore to make sure that they're providing HIV testing in residential settings and outpatient settings, etcetera.

And really the key to being able to work in any of these types of settings whether they're public, private, clinical or non-clinical is finding a key champion who is interested in HIV testing, who can talk with us about the mission and understand the goals of the program and are really able to be an internal champion within their setting or within their system to promote HIV testing and to talk about how to make that - to operationalize that in their setting.

We as I mentioned we really view HIV testing as part of a continuum and as part of a comprehensive system that includes linkage to care and partner services.

And as such we work with any HIV testing provider again public or private to ensure that individuals who are being diagnosed either newly or previously diagnosed with HIV are linked to prevention care and supportive services.

And we certainly provide partner services to ensure that clients at greatest risk for HIV infection are aware of their serious status. We work with partners of HIV positive individuals, and we have also begun a number of initiatives working with settings that have prevalent positives, people who are known to be positive to ensure that they're offering partnering services along a person's life span and at times of opportunity where we may need to go back and offer partner services to new partners for those previous or continuing positive individuals.

So what we've done over the past few years with the CDC recommendations and the change in our law and in conjunction with expanding testing initiative is a significant amount of provider education.

We've designed a number of different educational materials, some toolkits, we mailed materials to over 14,000 providers in partnership with our Maryland medical society which is called MedChi, that included a packet jointly signed by our secretary and MedChi's president that included the CDC recommendations and a description of the changes in Maryland law.

We issued practice advisories on the changes in Maryland law across clinical and non-clinical settings and we've done a number of trainings on CDC recommendations for routine HIV testing, the changes in the law and other opportunities to expand the provision of routine HIV testing.

We also did two additional things that I couldn't fit on the slides. One was we actually met with our Maryland insurance administration and all of the major private insurance providers in the state to talk about the CDC recommendations, the changes in the Maryland law.

And what we might do to work together to overcome barriers to third party reimbursement for routine HIV testing. And we did a similar dialogue with

the Maryland Medicaid care organization medical directors to again promote the offering of HIV testing in our Maryland Medicaid program.

In addition to the provider education we've done a significant effort in technical assistance and capacity building. Our staff works hand in hand with any entity, again public or private that's interested in offering HIV testing to ensure that they're able to navigate our state regulations and other requirements for rapid and conventional testing.

We have an additional concern or issue in Maryland in that rapid tests are not currently waived or not viewed as being waived so we have a close relationship with our office of healthcare quality that allows us to work with any entity to fill out the proper paperwork, to get the proper licensure and then to do the quality assurance that's required in our state.

And then we do capacity building with these entities to ensure that they have the appropriate testing policies and procedures in place, that they've been trained with the appropriate types of pre-test and post-test counseling and that they understand what the system is for linkage to care and the offering and implementation of partner services.

And the last slide is really challenges and opportunities. I think we've made significant strides in our state to increase HIV testing opportunities and the offering of HIV testing on a routine basis as well as public awareness about the importance of at least an annual test in our state.

But I think there are still some areas that we need to grow in. We do need to continue to partner with our clinical providers to increase the sustainability of routine HIV testing programs.

Again the ETI program has primed the pump in many settings but we need to work with them to build the systems that need to be in place to really maximize third party reimbursement as well as other resources in their own systems to continue these programs.

We need to continue to think about how to leverage non-public health resources to maximize the impact of public health dollars, certainly we're optimistic that healthcare reform will allow us some opportunities in that area as HIV testing may become an A or B recommendation by the US public health task force.

We're hopeful that that will lead to greater third party easier and greater third party reimbursement. We know we need to continue our system level integration efforts to increase testing in clinical and social service settings, again in behavioral health settings.

We need to work more intensively with our community health centers. We need to move into a new area in terms of what our quasi-primary healthcare settings such as the settings that are in chains like the Wal-Marts and the CVS's and the Targets to ensure that they have the capacity and the resources to offer HIV testing in the future as well.

And then of course we need to always work on increasing coordination between prevention and care programs to ensure that people living with HIV arte effectively linked to HIV prevention care and supportive services.

And I like the other presenters have contact information as well and I look forward to the question and answer period. Ann?

Ann Robbins: Great, it's always tough to follow Heather but I will do my best. I'm Ann Robbins and I'm the manager of the HIV STD program at the Texas Department of State Health Services.

And I like Heather would also like to thank my leadership including Dr. David Lakey for being so supportive of our efforts to expand access to HIV testing and his especial interest in working with his colleagues to promote offering of routine HIV testing in medical settings.

But I would be doubly remiss if I didn't point out that the information and the insights that I'm going to present today are jointly the product of work between the state health offices in Texas and the local health office in Houston, the Houston Department of Health and Human Services has had a great deal of influence and has done a good deal of the work in exploring new and innovative ways to integrate HIV testing into routine health offerings at many of the settings.

So hats off to them and much of what you'll see here is inspiration and perspiration is largely due to their efforts.

All right, what I'm going to do now is show you the Texas consent law, short and sweet and very, very broad.

This law has been in place for more than a decade and is responsible for how easy it was for us to move into routine HIV testing in our STI clinics.

And how easy it was for a law that required opt out testing of pregnant women at their first pre-natal visit and again at delivery was implement for syphilis, hepatitis B and HIV.

But what I also want to emphasize about this law which does not require separate written consent for HIV but does require that the patient be informed, that alternatively you can use a general medical consent to conduct the HIV testing is that uniformly every place we go legal department is one of the first stops in conversations.

Because in none of the places where we have been able to work successful with administration and clinicians to implement routine HIV testing in medical settings have we been able to do that without a serious and pretty pointed discussion with counsel.

And this points out of the difference and the importance of following a policy or a regulation down to the enactment level, in most of the sites before beginning our interactions with them on reaching testing.

These sites had separate written consent requirements, they had requirements for counseling in place. And we have been able to work with them to remove them.

Those were experienced as a burden by the clinical staff, by the administration and was a barrier to implementing routine testing at many emergency departments and other primary care facilities.

Was also felt to be a burden within public health programs such as TB. So despite having very broad and favorable laws on the books in Texas for many years that would seem to promote integration of HIV into primary care concerns, we found that they had - that many facilities had idiosyncratic and more conservative understandings of what the law required.

And so I just wanted to say make sure you make a stop on your implementation train for looking at the way the policy, procedure and regulation is understood at a local area - in local enactment sites.

And so while Heather did a wonderful job of talking about how these facilities are - how her program is a part of a troika if you will of approach to targeted testing, routine testing and then public health follow up.

That all melds into one larger philosophy and pursuit of availability of testing. I'm going to emphasize only the testing that's going on in clinical settings as a result of the expanded testing initiative.

And the data that you will see on the screen now while it does say through November 2010 really represents efforts through about September or October because there's reporting delay.

And I'm happy to say that our 28 sites by the end of the year will be blossoming into about 40 sites. These are 40 separate facilities and sites that have integrated HIV testing into their routine health offerings.

And these sites use a variety of models that all have one goal. And Heather has pointed that out and my colleagues at the CDC have pointed out, sustainable integrated routine HIV testing.

As you look through these data here you'll see that the largest number of tests in this project have been done in emergency departments, about 85, almost 86,0900 out of the 204,000 tests done over the last two years.

But that is not the facility type with our highest positivity rate although it is the facility that has garnered the most positives and that's about 1,000 positives found through those efforts.

The highest positivity rate belongs to STI clinics and the expansion here is allowing more certain delivery, its use of rapid tests to allow more certain deliver of results.

All in all about 2,000 positives were discovered through these efforts with out about - that means 1.1% which is far in excess of what the 2006 recommendations would indicate would be a productive level of testing.

So everyone is quite pleased with the productivity of this program in terms of numbers of positives.

But like Heather indicated and Julie indicated a number of these positives depending on the site between 30% and 50% of these positives are previously identified.

Although we've discovered through some preliminary analysis that even among those previously identified positives, that about 40% to 50% of those persons were not actively enrolled in care at the time of the subsequent HIV test.

So we are busy looking at these data to see what we can do to bring that wisdom to bear and make the stronger argument for examining the linkages in the present system to make that initial diagnosis one that helps the care referral stick.

I do want to point out as we look at these multiple models that for the most part with the exception of a few very large projects that are focused around emergency departments that the support offered to these facilities is technical assistance, and access to testing materials, whether that's access to the state health laboratory or purchase of testing kits for the facilities.

In a couple of the larger projects at correctional facilities and emergency departments we have supplemented systems of referral and we have by funding what are known as service linkage workers to help newly identified or previously identified positives make an effective link into care.

They follow and work with the clients and link them up with peers and other support systems in programs that are in place in the local area.

But we have also used these funds in some instances to shore up public health response and that is more specifically providing funds for DIS. And that is something that we need to consider about how to sustain and continue you know outside of a special project mentality.

The purpose of the expanded testing initiative was to assure that the access goes to populations that are disproportionately impacted and as you can see and we'll just go over this very briefly, a little bit more than a third of the tests were for African Americans, almost a third for Hispanics.

So two thirds of the tests are focused on racial or ethnic minorities, and if you look at the pie on the right you'll see that more than half of the HIV infected persons discovered through this program were African American or black with an additional 18% or 70%, 7 out of 10 of the positives belonging to racial or ethnic minority groups.

So I'm going to flip flop this a little bit and talk about best practices before challenges. As Heather and many, many others have pointed out, you have to have champions.

And we would submit that you have to have a team of champions. You need a clinical champion, you need a champion in a laboratory if you're talking about

going into a facility, whether it's a community health center, whether it's an emergency department, whether it's a chain of commercial concerns, that you have to have the folks there that make decisions about clinical protocols.

You have to have persons there who are knowledgeable or making decisions about the way that laboratory procedures are done because this is after all a - something that involves lab.

And you have to have you know other champions from different parts and I would say at the very beginning your legal champions as well.

They all need to be a part of designing the protocol and the approach, all need to be a part of making sure that they stay involved and stay working on there because as I wrote down at the bottom quality assurance is essential for assuring a successful program.

Because good practices need stamping in. I'd also like to draw your attention to assuring that you make close examination of the laboratory technologies and bringing those folks in to make sure that all platforms and all procedures are making best and most efficient use of the technology.

We found that in many of our settings we can run a standard result and run a standard test and give a rapid result and use of these standard tests are much less disruptive to the clinical practice.

And finally I would encourage our partners in local and state health offices to use their convening power because one of the most powerful forces that have promoted routine - adoption of routine testing, adoption of the CDC standards has been our peer network.

Our Test Texas HIV coalition and that's a broad group of practitioners that come from many perspectives that have joined together to meet, they share best practices, to share experiences on a regular basis.

And they meet and share face to face, but they also share through Websites and other sort of Wiki sites. I'm going to move on to looking a little bit further down the road.

And just talk very briefly about what's next. If you'll notice on most of our sites we're very large, they were academically oriented, these were either EDs that were associated with the public health hospital or teaching facilities.

They were traditional allies, corrections, family planning, STI clinics. One area that we have failed to be as successful as we want to be is integrating routine HIV testing into the prevention offerings that primary health centers and private practices.

And again the troika of challenges reimbursement, a belief that this is - that HIV testing, HIV infection, prevention of HIV infection is not relevant for the patients in those practices has come up over and over again.

And a lack of belief that their patients are - meet the criteria for inclusion of reaching testing which is 1 in 1,000 test results being positive.

We also believe that understanding what's next involves moving beyond the once in a lifetime test to understanding how to interpret the CDC guidelines for subsequent testing.

After that initial test individuals should be tested only if they are at enhanced risk or high risk for HIV. But understanding who in a practice is at higher risk

for HIV will involve more integration of sexual health, sexual history taking and discussion than we see practices in the environment currently.

So in response to that we are going to focus future efforts on working directly with primary care centers and professional organizations of private practitioners and moving and taking a page out of the success story with pharmaceuticals and actually looking at how do we detail out to these practices?

And I look at the clock and I see that once again we are at a time limit and I want to leave plenty of time for questions. So I will end my story there, thank you.

Dr. Judy Monroe: I thank both of you for really excellent presentations. I will tell you when I was state health officer in Indiana when you guys were talking about the champions, I always was impressed with the natural champions that are in our communities and out there to take on different challenges.

And I like the - Heather what you said about the key champion and certainly the testing program, I think both of you have described very well how the testing programs really are the keystone.

So I think all of our speakers on today's Webinar have really provided the tone for a very productive and informative Q&A discussion. So as we get set up here for the first question I want to emphasize again that we want your input.

We need your input, this is really our inaugural Vital Signs Webinar and this meeting is meant for you, all of you out in the field.

So we want to be productive and we want to be - make sure that we're very relevant to your needs. So remember after 3:00 pm there will be a short survey or actually past that hour on the OSTLTS Website, so you can go to www.cdc.gov/ostlts, our new acronym in the alphabet soup that we all have.

And click on Vital Signs Webinar in the Flash module at the top of the page. Your - all of you, your input is valuable to us as we move forward with this series. So operator, do we have our first question.